File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 3 - 2 5

2. STATE: Massachusetts

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/1/93

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
12 CFR 456.2 58 FR 15312

7. FEDERAL BUDGET IMPACT:
a. FFY 93 $ -0-
b. FFY 94 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
[illegible]

10. SUBJECT OF AMENDMENT:
Utilization review

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
Not required under [illegible]

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen

13. TYPED NAME: Bruce M. Bullen

14. TITLE: Commissioner

15. DATE SUBMITTED: December 31, 1993

16. RETURN TO:
Division of Medical Assistar
600 Washington St - 5th
Boston, MA 02111

Attn: Commissioner's offic

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/30/93

18. DATE APPROVED:
6/6/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/93

20. SIGNATURE OF REGIONAL OFFICIAL:
Ronald Preston

21. TYPED NAME: Ronald Preston

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Revision: HCFA-PM-85-3 (BERC)
May 1985

State: Massachusetts

OMB NO. 0938-0193

Citation 4.14

(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

X Utilization and medical review are performed by a Utilization and Quality control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.*

* The state performs the reviews in state-owned non-acute hospitals.

__ Utilization review is performed in accordance with of 42 CFR Part 456, Subpart H that specifies the conditions of a waiver of the requirements of Subpart C for:

___ All Hospitals (other than mental hospitals)
___ Those specified in the waiver.

X No waivers have been granted.